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ABSTRACT

This literature review examines the effects of hospitalization on the young child and suggests ways in which parents and hospital personnel can protect children from the potentially harmful emotional and intellectual effects of hospitalization. The history of attitudes toward the hospitalization of children is discussed. Children's emotional reactions to hospitalization (i.e., bewilderment, withdrawal, redefinition of body image) and their success in dealing with the anxieties of the hospital experience are examined in terms of long-term mental health. It is suggested that efforts should be made to provide "mothering-type" care to hospitalized children, but not to the extent that a feeling of dependency is fostered in these children. Hospitalized children's intellectual development is stressed. Methods in which the hospital environment can provide sources for stimulation and exploration are suggested. Hospital administrators, educators, parents, and medical professionals are called on to develop education programs to increase public awareness of the importance of the hospital stay for the young girl. (BRT)

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THE YOUNG HOSPITALIZED CHILD

Part 1: History page 1

Part 2: Emotional Development 4

Part 3: Cognitive Development 11

Part 4: Trends 16

Part 5: Conclusion 18

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Part 1: History

Throughout recent history, the detrimental effects of hospitalization upon the young child have been noted. In 1722, a plan to establish a residential institution for the treatment of young children was discarded because, "A very little reflection will clearly convince any thinking person that such a scheme as this can never be executed. If you take away a sick child from its parents or nurse you break its heart immediately..." (11,126)

Child care knowledge increased, but various aspects of that knowledge grew independently and unevenly. In referring to early nineteenth century care of the hospitalized child, Arthur Stein asks, "Could it not be that in an age of high pediatric illness and mortality, the groundwork development of children's facilities was made more effective by ignoring the child as an emotionally reacting individual?" (52,425)

In the early to mid nineteen hundreds, children's hospital stays were lengthy and for serious illnesses. Parents were restricted to as little as an hour's visiting a week. The emotional needs of children so isolated were only gradually recognized. In 1948 the Curtis Report in Great Britain recommended that, "Children who for any reason whatsoever are deprived of a normal home life with their parents or relatives should be cared for in small family groups so that they could experience the stable relationships and the rich emotional life that the more fortunate child finds in the family." (11,99) In that same year, William

Langford stated that some of the child's problems during hospitalization and after release could be averted if he is "treated as a thinking, feeling, acting human being." (38,242)

In the fifties, interest grew in the hospitalized child. The Platt Report, entitled "The Welfare of Children in Hospital," was published in 1959 as the result of committee work sponsored by the Central Health Services Council of Great Britain. Its recommendations included: live-in provisions for parents, no restrictions on visiting hours and upgrading of staff training regarding children's emotional needs. (58)

In 1952, Dr. James Robertson produced a now-classic film, "A Two-Year-Old Goes to the Hospital," which has been called "the first systematic attempt to evaluate the need for primary prevention in mental health." (12,1) This film, undertaken as an experiment in scientific recording, shows the child (Laura) to which nothing outstanding happens: medical attention is excellent, parents visit as allowed (every other day), and there is nothing "even remotely resembling cruelty." Yet Laura is shown on film as very upset, withdrawn, apathetic. Anna Freud says, "During the eight days (of her hospitalization), her personality undergoes subtle but increasing changes in directions which are ominous to the trained observer." (13,281) Robertson's film and his book, "Young Children in Hospitals," published in 1958, influenced the committee which wrote the Platt Report; and the 1970 edition of his book comments on the effects which

that report has had on child care in the hospital.

In the second quarter of this century, hospital care of children was geared toward "problems of infection, diarrhea and nutrition." (12,7) With the discovery and widespread use of antibiotics, and early ambulation of surgical cases, the complexion of children's wards has been greatly altered. (37,667) Today, half of the hospitalized children are admitted for congenital disorders. (12,7)

Due to early identification and screening programs, children's physical problems are beginning to be discovered earlier and children are admitted for treatment. These problems were formerly ignored for a variety of reasons, unless they became incapacitating. The children of poverty, whose problems are usually identified later than those of middle-class children, are likely to be hospitalized for a longer stay, when their problems do come to the attention of medical personnel. (11,2)

Currently, hospitalization is also used in child abuse cases to accomplish a variety of goals including: safety for the abused child, a "respite for overwhelmed parents," and adequate time for professionals to evaluate the case and extend their services. (29,51)

That there is need for consideration of the non-medical needs of the hospitalized child is made evident by statistics alone. In 1963, one million children were being hsopitalized each year; approximately forty percent of each child's day was occupied with physical and medical care. (4,10) What is done

with the rest of the time? What is done to prepare the child for the hospitalization experience? What is or should be hospital policy regarding these various non-medical problems: Can hospitalization be a growth experience for the young child?

Part 2: Emotional Development

Thesi Bergman says that "It speaks for the normal child's versitility and adaptability that even severely upsetting experiences can be weathered provided that an adequate measure of support, understanding and comfort is forthcoming from the environment." (1,30)

However, a child's methods of coping may be pushed beyond capacity: "If forced to meet excessive anxiety undefended, the child may be thrown...into stark despair and hopelessness." (1,90) Guidelines for the emotional care of the child, in or out of the hospital, have proved more elusive than medical or educational remedies. "It is, perhaps the mental welfare rather than the physical welfare of the child that tends to be neglected the most." (21,11)

Commenting on this problem, Bergman says, "It proved less easy, and more revolutionary to provide also for the child's emotional and personality growth, neither of which is at a standstill during illness but for which the hospital setting, even at its best, cannot offer normal or wholly suitable condition." (1,20)

Children's reactions vary widely, from hour to hour, according to age, background or illness. Generally three behavior types are manifested: irrepressible (hyperactive), unhappy

(crying and withdrawn), and bewildered (upset and acting out). (30,26)

The child's self concept is crucial to his handling of his hospital experiences. This self concept, "the way he can build his defenses and tolerate pain and separation from home, will be influenced by the way the family can handle their anxieties and frustrations, can support, or might neglect him." (43,96)

In his egocentricity, the child views hospitalization in terms of his own psychic reality, that is the fears and fantasies relating to his own experiences. (35,13) A child's body image, a three-dimensional picture of himself, is affected by his changing and maturing attitudes. Milton Fujita says, "Children are most perceptive of body integrity and its surfaces." (27,641) One has only to note fads and styles to realize children's interests in minor differences between themselves and others. A hospitalized child's body image is affected by: the attitudes of others, his own developmental stage, and his own medical problem. "The quality of his relationships with significant others is crucial in reintegration of his body image." (27,648)

Children who have some psychological distrubance are more likely to be damaged by hospitalization. Likewise children with death in the family or other severe stress, will be vulnerable. Many researchers have noted distinct differences in reactions of children depending on their particular medical problem.

Orthopedic patients, partially because their apparatus was highly visible, accepted treatment in a positive way.

Bergman says the "stark and uncompromising reality of the situation ...helped to keep fantasies and unrealistic anxieties in check." (1,60) In contrast, cardiac patients, in the absence of equipment, feel a "mysterious internal ailment, difficult to verify." The function of the heart is a vague concept to the child. To these children, the "body and the heartbeat assumed the role usually held by the important people in a normal child's life." (1,71)

Children whose body image is changed via surgery or restricted by a cast, etc., often "develop a distorted inage of their body and its functions." When a child is not able to perform functions which may be only newly learned: toileting, self-feeding, dressing, he tends to feel helpless and he thinks of himself as a much younger child, (10,63) A child who has been restricted in a cast, has repressed great anxiety and tension which often break through in the form of agression when the cast is removed. (1,65)

In differentiating the chronically ill child from the fatally ill child, John Spinetta found a higher degree of anxiety and "a preoccupation with threats to bodily integrity and functioning" in the fatally ill child. Even though he is not yet capable of discussing his illness and his death, he appears to be aware of the seriousness of the situation. (51,841)

Children facing kidney transplants or undergoing dialysis manifest "personality maladjustments or behavior problems," but these "rarely develop de novo in this situation." (34,628)

Figuratively, the child brings his family and his whole lifetime of experiences with him to the hospital. The child's postoperative reaction has been called "psychic shock" by Pearson. This phenomenon stimulates his imagination which in turn adds to the shock. The child may attack personnel or equipment, or attempt to escape by withdrawal. (48,37)

In studying traumatic situations, Bergman found that some children had "latent conflicts" which were activated and heightened by illness, hospitalization and immobilization to a degree which threatened the success of hospital treatment and obstructed the child's path to recovery." (1,12)

A child in the hospital is experiencing the same emotions as a healthy child; he can be happy depressed, hopeful, anxious. There are however, extra factors added to the emotional aspect of a sick child, In a well child,"when newness brings forth novel and interesting possibilities, there is motivation to master it for the sake of the obvious rewards. However, when pain or loss or both are involved, stress is multiplied, the rewards are uncertain and the problem of mastery is intensified. In times of pain or stress, the child needs extra support and encouragement to deal with the problem of mastery." (35,21)

It is felt by many that his success in dealing with the anxieties of the hospital experience will greatly affect his future mental health. (35,21) A key factor in the long term effect of stress seems to be "the degree of rejection or insecurity felt by the child." (40,845)

Especiallly at risk are those children whose method of

communication is not yet verbal and who are young enough to especially fear the loss of mother. Bergman says the most endangered age group is from one and a half to two and a half or three years of age; they "have the worst of both worlds." They are developing independence from the mother and hence are not totally supported by her and yet they are too immature to understand what is happining to them. Their ways of dealing with stress are limited to "panic or massive regression." (1,47)

Regression also occurs in patients who have not been able to acknowledge their overwhelming feelings. Defense mechanisms take all their energies and when the imminent danger passed, the defenses broke down and the "denied emotional content returned with a vengence, incapacitating the patient." (1,29)

When children are hospitalized for a second time, they do not feel the confidence of familiarity. "On the contrary, sensitized by their initial experience, it is common for them to meet every subsequent operation with incresed anxiety... increased resentment." (1,27)

Joyce Robertson kept a three month diary of the pre, during and post hospitalization behavior of her child who experienced a tonsillectomy. Anna Freud calls this account "not only an interesting description of operation and hospitalization but also... a convincing and consistent report on the inner struggle between the anxieties which were aroused by the experience and the infantile ego's attempt at dealing with them." (47,428)

A study in the Boston area interviewed forty children age six to nine during their first hospitalization. The study concluded that these children had already learned the value of conformity in the hospital. "One wonders how much conformity children of this age can tolerate without having it seriously affect their emotional growth." (14,104)

A study of the drawings of second graders was done in order to determine a well child's concept of hospitalization. Those who had never been hospitalized drew pictures that were generally neutral and concerned with equipment. Children who had been to the hospital drew more vividly, were more specific and concerned with the patient. The drawings emphasized the familiar (food, television) to gain security, but the general theme was loss of independenc. (33,20)

The adults which a child encounters in the hospital can make a significant contribution toward his emotional growth. If the adult can treat the child openly and with respect, the child will be sensitive to his sincerity. There is some disagreement as to how easily the child can transfer attachment from mother to another adult. Kuzman says that this change is not easy since the hospital environment is not familiar to the child, and especially if the child's previous associations are limited. (35,15)

If there is a substitute available to perform the mothering functions which are essential to a child's security and well-being, the child can develop a relationship which can not only reduce

the stress of separation but also "sustain his experience of responsive 'mothering-type' care." (46,1611) A sympathetic person unconnected with medical care, can reassure the child and provide a "needed link to the outside." (30,26)

Even with the best hospital policy, fragmented child care does occur. "One can then see the classical signs of despair and depression go unattended, even unnoticed." The essence of care involves giving the child time and attention when he needs it from people to whom he is attached. Robertson and Robertson suggest foster care, seven days a week, to support those children who otherwise will slip "through the net of good intention." (46,1613)

In a discussion of helps to the emotional well being of a hospitalized child, one should remember that "Children are much more resilient than is often recognized." (22,823) They should have assurances that fear is not a "reflection on (their) personal integrity." (48,37) "Acting out" should be permitted so that the child can express his fear and rage; then he will be free of these emotions and "free to cope with the situation by more positive means." (1,28) The very young child cannot understand reasons for his situation. Food and affection are closely linked in his life. When both are unfamiliar, meals may be resisted. (2,31) A calm person, a bottle or pacifier may be comforting to him. Toddlers value their new independence and must be allowed to care for themselves as much as possible. Telephones, even windows provide links to home and to outside. (28,16)

A hospitalized child grows to depend on the infantilizing

experiences but Wolinsky says, Only when health holds greater compensations than illness will they give up invalidism and special privileges." (49,27) At bedtime, time and effort are important to provide "undisturbed sleep (which) will help in the healing process." (2,34)

Part 3: Cognitive Development

Cognitive development refers to the changing ability of the child to understand himself and his world. (54,308) A cognitive program is an essential aspect of rehabilitation. "What happens and what does not happen to the sick child to a great extent determines the nature of his behavior not only within the hospital but for a long time after he has returned home." (12,vii) Dane Prugh holds the theory that given the low correlation between the frequency of parental visits and the child's adaptation, one could assume that "the more diffusely supportive aspects of the (child life) program were the most prophylactic in effect." (45)

The policy of the hospital, itself a function of public education, community pressure and the state of the art of non-medical child care, determines what happens to the hospitalized child. Budget limitations sometimes mean that the funds available are directed toward children with obvious and extended needs. Preventive medicine vis a vis hospitalization's dangers are neglected. (7,63)

Staff and parental concepts often hinder the development of a good program. "The greatest problem which blocks the understanding of the child's emotional needs is the adult's unfamiliarity with the child's subjective irrational, and emotional

approach to life." (23,1170) When hospital policy does not recognize the cognitive needs of the short term patient than an education program will not be forthcoming. (7,70)

A hospital policy should be established to "protect children from the effects of separation, isolation and reaction to medical procedures." (4,17) The hospital environment can mitigate against depression by providing sources for stimulation and exploration. (10,53) A hospital education program should be "part of the supportive environment which speeds recovery and return to the realistic goals of achievement." (7,64) An ideal policy allows for a flexible program and fluid planning with the main theme being, "how can we help each individual child that day." (7,63)

While practical application lags far behind the theory, researchers agree that the child's intellectual development is a responsibility of any institution which purports to care for him, even though such an institution's raison d'etre may not be the cognitive growth of the child.

The value of a teacher is stressed by Dr. Charles Haskins. "One teacher hour which changes hopelessness to hope, distress to peace, or chronic illness to the promise of health has more value in my mind than thousands of teacher hours which give ABC's only and no stimulation to individual and group betterment." (55, 104) Alex Haller praises the philosophical outlook of a person "who can see that a day spent teaching a child who may die tomorrow has merit among the achievements of men." (7,61)

Most children in the hospital whatever their degree or stage of illness, will benefit from a program of cognitive development emphasized equally with their medical care. (14,435) In discussing the differences between the learning-related characteristics of the well and the sick child, several items are usually mentioned. The sick child may be easily fatigued, and have a shorter span of attention. His spontaneity and initiative may be notably diminished as his hospital-acquired dependence takes over. These qualities of the child plus his ever changing medical status, mandate both a flexible curriculum and approach. (7,61)

Thesi Bergman refers to the child's anxiety over illness and hospitalization as working in a positive manner. The children she studied were "more receptive to learning than they had been" before hospitalization. (10,54) This may be explained by a one-to-one relationship with the teacher, or by the removal of peer and home distractions. At any rate, the child senses that the hospital's attention to his intellect means that the staff is certain that he will recover from his illness. (7,35)

In order to maximize the aid given to a child, Sally Jean says that his "mental and social progress must match or even exceed physical improvement if ...(he)...is to be in a true sense rehabilitated." (32,183)

Consideration of the child's feelings means that the child should be included in the planning for his care. (24,67) It is important that the child have an opinion of his own. The

child should not be demeaned by such admonitions as, "Be a good boy." (52,328) He needs to feel that he matters as a person. (2,30)

The child's concept of the body is often that of a hollow skin-covered organ, sometimes containing food. (33) His immature concepts must be aided. A mirror in the room helps him to see that while there is damage to the functioning of his muscle, his body image is not distorted. (10,63) Sometimes a child with pre-hospitalization problems in school, will use his sickness as an excuse for non-participation in the educational program. (34,628)

The learning environment of the hospital shows respect for the child when it allows him to select "tools that invite involvement and success." Decorations should be meaningful to the child and the limits of the environemtn should be non-verbal. (57)

Outside entertainment for the child can be of value but the kinds of programs must be carefully monitored. (19,438) Emma Plank says, "The child does not need diversion to get well, but opportunities to participate with all available emotional and intellectual energy in their daily living." (10,57) Activity and participation are "needed to balance the enforced passivity and dependence." (10,46) An environment which is bare, "offers little stimulus to the basic process of differentiation and mastery of the environment, as well as offering little sensory gratification." (3,72)

According to many theorists, "A child actually enjoys the intellectual restrictions of an orderly life." (44,489) This order diminishes self anxiety and helps him to look at the

outside world. Thus, a planned education program contributes greatly toward the child's mental health. (2,37) A hospital program which serves the child best is one which emphasizes the healthy part of the child, (17,19) and turns "the passivity of the patient into the activity of the growing child." (10,58)

Many times the ages, abilities or disabilities of the children facilitate teaching in "family groups." The constantly changing nature of the group necessitates some modification of a normal nursery school setting. The young child is more susceptible to the detrimental effects of hospitalization because of an undeveloped ability in communicative skills, reality testing, and fewer social experiences. (23,1170) Nevertheless, often in the hospital, "Children help each other face the realities of illness." (23,1169) In addition, the more personal contact with a teacher somewhat replaces the benefits of being a member of a class. (10,47) Joyce McLellan says, "Discussion with other children and with adults is one of the principal ways in which children check their concepts against those of others and build up a concept of reality." (8,56)

"Babies in particular are in danger ...unless they are talked to, played with or stimulated in a warm mothering way." (42,536) Babies also need rest and quiet, just as essential, and sometimes more difficult to provide than stimulation. The challange is "to offer enough opportunity without overstimulation." (19,438)

Infants need visual and auditory activities, i.e. practice in focusing their eyes, in tracking. (56,36) They

ideally should be placed in self contained units with one nurse and three or four infants, Warm floor places can provide crawling place and facilitate tactile and kinesthetic stimulation.'28,15) The primary consideration for infants however, is to provide comfort to counteract their maternal loss grief. Talking to him, holding him, propping him up to look around are stimulation against such loss. (10,35)

Part 4: Trends

Three needs are stressed in the literature: child care knowledge, mental health awareness and preparation for the child. The need for wide dissemination of child care knowledge is obvious. "We will be able to create optimal methods of caring for young children in the hospital only when we have learned to base them on an adequate understanding of the young child and his emotional needs." (11,6) Hospital routines are sometimes based on tradition when the original necessity for that routine no longer exists. For example, bathing a child upon admission stems from an earlier time when standards of home cleanliness were not high. The hospital staff often resists changes in their working procedures which would ultimately benefit the child. Arthur Stein calls this "resistence to psychological prophylaxis, a maturational crisis in sociomedical organization and practice." (52,450)

The importance of mental health to change in policy is also obvious, "When it becomes sufficiently understood that as much attention has to be given to mental health as to asepsis,

no consideration of administration or status will be allowed to stand in the way of providing the optimal system of nursing." If mental health implications are not sufficiently understood, there may be resistance to changes in areas of procedure which theretofore had been adequate and efficient in treating physical illness. (11,100)

Preparation should have high priority. "If we but appreciate the great significance of adequate preparation of the institution, the staff, the family and the child for the creation of a happy and emotionally healthy hospitalization, proper steps will be taken to reduce the frequency of residual psychic damage." (7,17)

The recognition of the role of the hospital child care worker is growing and the enhancement of its professional status from within and from without is developing. This profession is the heretofore missing link, which has the potential of quietly but definitely turning the attention of the hospital administration, medical staff and indeed, of the general public, toward the child "beyond the stitches."

One possible outcome of the increase in awareness of the importance of this experience in a child's life, is that there may be established groups of educators, parents and medical professionals to sit as an advisory board with policy making power, to improve the quality of child care in the hospital. This type of board could be established by the government,

nationally or locally or it could be set up by an individual hospital. The present organization of professionals is a tremendous beginning but the scope needs to be enlarged to include parents and the influence needs to be expanded to include policy and budget.

Part 5: Conclusion

Plato once said, "The greatest mistake a physician makes is to attempt to cure the body without attempting to cure the mind; yet the mind and body are one and should not be treated separately."

There is a lag between child care knowledge and practice which is rapidly being decreased. The more that parents, hospital administrators and staff, researchers and educators realize that they have one goal in common: the protection of the child from the potentially harmful effects of hospitalization and the growth and development of the total child during that experience, the faster the implementation of good child care will take place.

Clearly the non-medical care of the hospitalized child has come a long way. The problems have been acknowledged and research is growing in many sub areas. We may look forward to the not-too-distant future when we "have learned to foster the development of each child with the right admixture of medicine, play and school." (7,65)

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